Texas Health and Human Services | Texas Department of State Health Services

Zika Case Investigation

☐ US Zika Pregnancy Registry
☐ Disease ☐ Infection
☐ Congenital ☐ Non-congenital

NBS Patient ID: ________________________

PLEASE PRINT LEGIBLY

Patient Information

Last Name: ______________________________ First Name: ______________________________

Date of Birth: _____/______/______ Sex: ☐ Male ☐ Female ☐ Unknown

Age: _______ Age units: ☐ Years ☐ Months ☐ Days

Street Address: ______________________________ City, State, Zip: ______________________________

Patient Phone: ______________________________ County of Residence: ________________________

Country of Birth: ______________________________ Date of Arrival (if not U.S. born): ____/____/______

Race: ☐ Asian ☐ American Indian/Alaskan Native
☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Unknown ☐ Other: __________________________

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Occupation: ____

Clinical Information

Physician: ______________________________ Address: ____

City, State, Zip: ___________________________ Phone: ___________________ Fax: _________________

Was the patient hospitalized for this illness? ☐ Yes ☐ No ☐ Unknown

If yes, provide name of hospital: ____

Dates of hospitalization: Admission ____/____/______ Discharge ____/____/______

Does the patient have an underlying chronic illness?	☐ Yes	☐ No	☐ Unknown
Is the patient immunosuppressed?	☐ Yes	☐ No	☐ Unknown
Is there a more likely clinical explanation for this patient's symptoms?	☐ Yes	☐ No	☐ Unknown
Is the patient deceased?	☐ Yes	☐ No	☐ Unknown

If yes, date of death: ____/____/______ (*submit documentation if due to Zika virus)*

Laboratory Findings

Test Type	Collection Date	Source	Result	Performing Laboratory
☐ PCR ☐ ELISA-IgM ☐ PRNT ☐ Other: ______________	___/___/____	☐ Serum ☐ Urine ☐ CSF ☐ Other: ______________	☐ Positive ☐ Negative ☐ Equivocal ☐ Indeterminate	☐ State/LRN Lab ☐ CDC Lab ☐ Commercial Lab: ____________________
☐ PCR ☐ ELISA-IgM ☐ PRNT ☐ Other: ______________	___/___/____	☐ Serum ☐ Urine ☐ CSF ☐ Other: ______________	☐ Positive ☐ Negative ☐ Equivocal ☐ Indeterminate	☐ State/LRN Lab ☐ CDC Lab ☐ Commercial Lab: ____________________
☐ PCR ☐ ELISA-IgM ☐ PRNT ☐ Other: ______________	___/___/____	☐ Serum ☐ Urine ☐ CSF ☐ Other: ______________	☐ Positive ☐ Negative ☐ Equivocal ☐ Indeterminate	☐ State/LRN Lab ☐ CDC Lab ☐ Commercial Lab: ____________________
☐ PCR ☐ ELISA-IgM ☐ PRNT ☐ Other: ______________	___/___/____	☐ Serum ☐ Urine ☐ CSF ☐ Other: ______________	☐ Positive ☐ Negative ☐ Equivocal ☐ Indeterminate	☐ State/LRN Lab ☐ CDC Lab ☐ Commercial Lab: ____________________

NBS Patient ID: ______________________ Patient Name: ________________________________

Signs and Symptoms

Symptomatic? ☐ Yes ☐ No ☐ Unknown

***If yes*, date of illness onset: ____/_____/______**

Fever	☐ Yes	☐ No	☐ Unknown	Myalgia	☐ Yes	☐ No	☐ Unknown
Chills	☐ Yes	☐ No	☐ Unknown	Joint/bone pain	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown	Rash	☐ Yes	☐ No	☐ Unknown
Conjunctivitis	☐ Yes	☐ No	☐ Unknown	Describe: ________________________________			
Retro-orbital pain	☐ Yes	☐ No	☐ Unknown	Vertigo	☐ Yes	☐ No	☐ Unknown
Severe malaise	☐ Yes	☐ No	☐ Unknown	Abnormal reflexes	☐ Yes	☐ No	☐ Unknown
Nausea/Vomiting	☐ Yes	☐ No	☐ Unknown	Paralysis	☐ Yes	☐ No	☐ Unknown
Diarrhea	☐ Yes	☐ No	☐ Unknown	CSF pleocytosis	☐ Yes	☐ No	☐ Unknown
Stiff neck	☐ Yes	☐ No	☐ Unknown	Oral ulcer	☐ Yes	☐ No	☐ Unknown
Muscle weakness	☐ Yes	☐ No	☐ Unknown	Other: ___________________________________			

Pregnancy

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown *If No or Male, skip to next section*

If yes:

Has a fetal ultrasound been performed? ☐ Yes ☐ No ☐ Unknown

If yes, note any pregnancy complications detected: ☐ No abnormalities ☐ Microcephaly ☐ Fetus with CNS abnormalities ☐ Intracranial calcification ☐ Fetal growth abnormalities

Is the pregnancy outcome known? ☐ Yes ☐ No ☐ Still pregnant

If yes, choose one of the following: ☐ Live birth ☐ Fetal loss ☐ Stillbirth ☐ Premature death of newborn ☐ Perinatal death ☐ Therapeutic termination of pregnancy

Date of last menstrual period: _____/______/______

Newborn

Is the patient a newborn? ☐ Yes ☐ No ☐ Unknown *If No, skip to next section*

If yes:

Provide vital status: ☐ Live birth ☐ Fetal loss ☐ Born alive and died ☐ Unknown

Note any complications detected: ☐ None ☐ Microcephaly ☐ Congenital CNS anomaly ☐ Intrauterine growth retardation ☐ Intracranial calcification ☐ Limb defects ☐ Ocular defects

Does the mother have evidence of Zika virus? ☐ Yes ☐ No ☐ Unknown

If yes, provide the mother's NBS investigation ID (i.e CASXXXXXXXXTX01): ______________________

Epidemiology

Clinical Syndrome: ☐ Asymptomatic ☐ Febrile Illness ☐ Other clinical ☐ Congenital infection ☐ Guillain-Barré Syndrome ☐ Unknown

Secondary Clinical Syndrome: ☐ Guillain-Barré Syndrome ☐ Other clinical ☐ None

Did the patient donate or receive blood, blood products, or organ/tissue in the last 120 days?
☐ Yes ☐ No ☐ Unknown

***If yes**:* Type of product: ☐ Blood ☐ Blood products ☐ Organ/tissue

Donation date(s): _____/______/______; _____/______/______; _____/______/______

Transfusion/transplant date(s): _____/______/______; _____/______/______; _____/______/______

Blood Collection Agency/Medical Facility: ____

For infants only, was the patient breastfed? ☐ Yes ☐ No ☐ Unknown ☐ N/A

In the 30 days prior to onset (or 12 weeks prior to diagnosis if asymptomatic); how many hours did the patient spend outdoors each day? ☐ <2 ☐ 2-4 ☐ 5-8 ☐ >8

When outdoors, what percentage of the time did the patient use mosquito repellent?
☐ Always ☐ 75% ☐ 50% ☐ 25% ☐ Never

Epidemiology continued

In the 15 days prior to illness onset, did the patient travel or reside outside of their current residence county?
☐ Yes ☐ No ☐ Unknown ***If yes, provide dates and locations on page 4.***

If asymptomatic and/or pregnant, did the patient travel or reside outside of their current residence county in the previous 12 weeks OR at any time during their pregnancy or in the 8 weeks prior to conception?
☐ Yes ☐ No ☐ Unknown ***If yes, provide dates and locations on page 4.***

Where was the disease acquired?
☐ International ☐ Indigenous ☐ In State, out of jurisdiction ☐ Out of State
☐ Imported, but not able to determine source ☐ Unknown

If acquired internationally, please indicate country: ____
If acquired within the U.S. but outside of Texas, please indicate city and state: __________________________
If acquired within Texas, please indicate city and county: ____

Has the patient had unprotected oral, vaginal, or anal sex in the 6 months prior to Zika infection?
☐ Yes ☐ No ☐ Unknown
If yes and in the absence of a travel history or other type of exposure*, please contact Regional Zoonosis Control Program for a supplemental sexual history form.*

Does the patient know anyone else experiencing a similar illness? ☐ Yes ☐ No ☐ Unknown
If yes, provide names and contact information on page 4.

Was the patient viremic while in Texas (for symptomatic persons, during 7 days after onset)?
☐ Yes ☐ No ☐ Unknown
If yes, provide dates and locations where patient may have been bitten by mosquitoes on page 4.

Transmission Mode: ☐ Vector-borne ☐ Sexual ☐ In-Utero (transplacental) ☐ Perinatal ☐ Blood borne
☐ Other (explain): ____

Public Health Control Measures

Were public health control measures initiated in response to this case? ☐ Yes ☐ No ☐ Unknown
If yes, what date were initial control measures started? _____/______/______

Select all control measures used: ☐ None ☐ Education ☐ Mosquito source reduction
☐ Larviciding (mosquitoes) ☐ Adulticiding (mosquitoes)
☐ Other: ____

Select all barriers to timely initiation of control measures: ☐ None ☐ Communication ☐ Equipment
☐ Funding ☐ Participation ☐ Policies/procedures ☐ Resource limitations ☐ Staffing
☐ Time constraints ☐ Training
☐ Other: ____

Investigation Information

Date First Reported: ____/____/______ Investigation: Started ____/____/_____ Completed ____/____/_____
Reporting Facility: ____
Name of Investigator: _________________________________ *(Please print clearly)*
Agency: ____ *(Please do not abbreviate)*
Phone: _____________________________ E-Mail: ____

NBS Patient ID: ______________________ Patient Name: ________________________________

Comments or Other Pertinent Epidemiological Data

Travel Dates and Locations Prior to Illness Onset or During Pregnancy/Periconception Period

Dates	Area/Street Address	City	State	Country

Other Persons Experiencing Similar Illness

Name	Telephone Number	Street Address	City	State

Locations of Possible Mosquito Exposure While Viremic

Estimated dates of viremia: from ____/____/______ to ____/____/______

Date(s)	Street Address	City	County	Comments